

# THIRD PART LIABILITY HEALTH INSURANCE INFORMATION

Michigan Department of Community Health

|                  |    |                                    |      |      |      |
|------------------|----|------------------------------------|------|------|------|
| FIA Grantee Name |    |                                    | Date |      |      |
| FIA Case Number  | Co | Dist                               | Sec  | Unit | Spec |
| Specialist Name  |    | Specialist Phone Number<br>(     ) |      |      |      |

## INSTRUCTIONS:

- Please PRINT or TYPE
- Retain a COPY in FIA Case File

- Fax: (517) 346-9817
- E-Mail: TPL\_Health@ Michigan.Gov

- Mail ORIGINAL to:  
REVENUE AND REIMBURSEMENT DIVISION  
BUREAU OF FISCAL REVIEW AND REIMBURSEMENT  
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
PO BOX 30435  
LANSING MI 48909

- This form and other information are also available through the internet at:  
[www.michigan.gov/mdch/1,1607,7-132-2945\\_5100-20412--,00.html](http://www.michigan.gov/mdch/1,1607,7-132-2945_5100-20412--,00.html)

## SECTION 1 - Policyholder #1

### Policyholder #1 Information:

|   |                         |                               |               |
|---|-------------------------|-------------------------------|---------------|
| Policyholder Name (Last, First, Middle) | Employer Name           |                               |               |
| Social Security Number                  | Employer City and State |                               |               |
| Insurance Company Name                  | Group / Policy Number   | Certificate / Contract Number |               |
| Service / Coverage Code (BC/BS)         | Carrier ID Number       |                               | Coverage Type |

**Recipient Information:** Include the policyholder (if applicable) and any other adults and all children covered under **Policyholder #1**.

|                                      |                  |                                      |                  |
|--------------------------------------|------------------|--------------------------------------|------------------|
| Recipient Name (Last, First, Middle) | Recipient ID No. | Recipient Name (Last, First, Middle) | Recipient ID No. |
| Recipient Name (Last, First, Middle) | Recipient ID No. | Recipient Name (Last, First, Middle) | Recipient ID No. |
| Recipient Name (Last, First, Middle) | Recipient ID No. | Recipient Name (Last, First, Middle) | Recipient ID No. |

## SECTION 2 - Policyholder #2

### Policyholder #1 Information:

|   |                         |                               |               |
|---|-------------------------|-------------------------------|---------------|
| Policyholder Name (Last, First, Middle) | Employer Name           |                               |               |
| Social Security Number                  | Employer City and State |                               |               |
| Insurance Company Name                  | Group / Policy Number   | Certificate / Contract Number |               |
| Service / Coverage Code (BC/BS)         | Carrier ID Number       |                               | Coverage Type |

**Recipient Information:** Include the policyholder (if applicable) and any other adults and all children covered under **Policyholder #1**.

|                                      |                  |                                      |                  |
|--------------------------------------|------------------|--------------------------------------|------------------|
| Recipient Name (Last, First, Middle) | Recipient ID No. | Recipient Name (Last, First, Middle) | Recipient ID No. |
| Recipient Name (Last, First, Middle) | Recipient ID No. | Recipient Name (Last, First, Middle) | Recipient ID No. |
| Recipient Name (Last, First, Middle) | Recipient ID No. | Recipient Name (Last, First, Middle) | Recipient ID No. |

## SECTION 3 - Insurance Cards

- Attach copies (back & front) of any insurance cards for anyone covered under either **Policyholder #1 or #2**.
- Also attach copies (back & front) of insurance cards for any additional coverages (i.e. **vision or dental**) available to those policyholders.